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ABSTRACT

The prevalence of suicidality among gay, lesbian, and bisexual youth is considerably higher than the reported rates for heterosexual youth. The strongest predictors for suicidality among all youth are substance abuse; victimization; social isolation; and exposure to suicide attempts or completion among family members. Homosexual and bisexual youth show significantly elevated rates for these risk factors. In addition, these youth experience other contributing risk factors for suicidality that differentiates them from heterosexual youth. The strongest predictors for suicidality, unique for sexual-minority youth, are gender non-conformity and younger age at time of homosexual identity formation. The population-based studies reviewed provided limited information about the association between religion and suicidality among youths. There is not just one risk factor most predictive of suicidal behavior among gay, lesbian, and bisexual youth, just as there is not for heterosexual youth. More likely it is the experience of multiple risk factors simultaneously in combination with low rates of protective factors that exacerbate suicidality among homosexual youth. It is hoped that the findings in this report might lead to the development of preventive interventions by identifying particular risk factors among these youth. (Contains 2 tables and 53 references.) (JDM)

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Prevalence of Suicidality and Contributing Risk Factors Among Gay, Lesbian, and Bisexual Youth

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The prevalence of suicidality among gay, lesbian, and bisexual youth in North America is considerably higher than the reported rates for heterosexual youth. It appears that gay, lesbian, and bisexual youth are vulnerable to similar risk factors for suicidality as heterosexual youth. The strongest predictors for suicidality among all youth are substance abuse, victimization, social isolation, and exposure to suicide attempts or completion among family members. Homosexual and bisexual youth show significantly elevated rates for these risk factors. Additionally, there is evidence that gay, lesbian, and bisexual youth experience other contributing risk factors for suicidality that differentiate them from heterosexual youth. The strongest predictors for suicidality, unique for sexual-minority youth, are gender non-conformity and younger age at time of homosexual identity formation. Religiousity presents another possible risk factor in gay youth suicide. However, the population-based studies reviewed provided limited information about the association between religion and suicidality among youths. Similar for heterosexual youth, there is not just one risk factor that is most predictive of suicidal behavior among gay, lesbian, and bisexual youth. More likely it is an accumulation of experiencing multiple risk factors simultaneously in combination with low rates of protective factors that exacerbate suicidality among homosexual youths.

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Prevalence of Suicidality and Contributing Risk Factors Among Gay, Lesbian, and Bisexual Youth

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June 18, 1998

Dedication

This paper is dedicated to my life-long role model, my mother, Diane Guzy Gup. Her unwavering encouragement, support, and love has been a consistent source of comfort throughout my life. Words can not express the love, appreciation, and respect I have for her.

Also, I am dedicating this research to my deceased friends (Russell, Rodney, and Mike) who struggled with similar issues which are presented in this paper. Though their lives were brief, they served as exemplary role models for youth, regardless of sexual orientation.

CHAPTER I

Introduction

Theoretical and empirical writings have made significant contributions to furthering our understanding of specific risk factors for suicide among youth. Research examining sexual orientation as a risk factor for suicide has emerged from the broader study of adolescent health risk-taking behaviors. The purpose of this Clinical Research Project (CRP) is to examine critically the literature on suicidal behavior and sexual orientation among youth. First, this review investigates if homosexual and bisexual youth are at higher risk than heterosexual youth for suicide and suicide attempts as well as the conditions to predisposing these outcomes (i.e. substance abuse, victimization, etc.). Second, this paper examines if the risk factors for suicidality and predisposing conditions vary by sexual orientation. That is, what are the predictors of suicide outcomes, and do they differ for homosexual and bisexual youth and heterosexual youth?

This review is organized around two main principles. First, the research is divided into two broad categories, prevalence studies and risk factor studies. Second,within each of these broad categories the research compares the findings across homosexual, bisexual, and heterosexual youth groups.

Within this general structure, several issues are addressed. First, when data are available more specific demographic data (gender, race, and age) are presented and analyzed. Second, the limitations and problems associated with having little consensus among investigators about how to define and measure suicide attempts and sexual

orientations are discussed. Third, there are relatively few studies that have been based on nationally representative samples. Sampling difficulties include the use of self-identified volunteers as subjects, small sample sizes; and, underrepresentation of nonwhite participants, women, and individuals living outside metropolitan areas. In the past few years there has been an increase of population-based surveys designed to investigate suicidal risk factors and sexual orientation (Binson, Michael, Stall, et al., 1995; Blum, McKay, & Resnick, 1989; Blum & Rinehart, 1997; Michael, Gagnon, Laumann, & Kolata, 1994; Remafedi, French, Story, Resnick, & Blum, 1998; Remafedi, Resnick, Blum, & Harris, 1992; Safe Schools Coalition of Washington, 1995; 1996; 1997). Accordingly, these population-based studies will be emphasized. This review concludes with the clinical implications for the treatment of homosexual and bisexual at-risk youth with suggestions for future research.

For several reasons the findings of this Clinical Research Project have clear relevance to the field of psychology. First, this research provides important descriptive information about the personal, familial, and community challenges of a population often neglected in the research. Second, "understanding the relationship between sexual orientation and suicide risk might illuminate the epidemiological trends in self-inflicted injury and death" (Remafedi el al., 1998, p.57). Third, these findings may lead to the development of preventive interventions by identifying particular risk factors associated with mental health problems in young gay males, lesbians, and bisexual people.

Suicide Rates Among Youth: An Overview

Suicide in adolescents and young adults is a national tragedy and a major public health problem. It is now recognized to be a major health problem for adolescents in the United States, accounting for approximately 5,000 (13.3%) of the 37,000 annual deaths in the 15-24-year-old age category (National Center for Health Statistics; as cited in Hershberger, Pilkington & D'Augelli, 1996). The suicide rates for adolescents 15-19 years of age have increased from 2.7 per 100,000 in 1950 to 11.3 per 100,000 in 1988 (as cited in Centers for Disease Control [CDC], 1991). Accordingly, in 1990 the Centers for Disease Control indicated that 276,000 high school students in the United States made at least one suicide attempt requiring medical attention during the 12 months preceding the survey (CDC, 1991). In 1995, as part of the Youth Risk Behavior Surveillance System, the Centers for Disease Control and Prevention readministered the national school-based Youth Risk Behavior Survey among a representative sample of 10,904 high school students in grades 9-12. Study results revealed that 24.1% of students had thought seriously about attempting suicide and 17.7% had made a specific plan to attempt suicide for the 12 months preceding the survey. Additionally, 2.8% of students had made a suicide attempt during the 12 months preceding the survey (CDC, 1996). In 1991, the Centers for Disease Control set the following national health objective for the year 2000: "reduce by 15% the incidence of injurious suicide attempts among adolescents aged 14 through 17" (p. 1911). The risk of youth suicide in the United States reached such epidemic proportions by 1989 that The US Department of Health and Human Services charged a multidisciplinary task force with investigating the potential risk factors suggested by

research studies (Report of the Secretary's Task Force on Youth Suicide, 1989). One of the characteristics linked to youth suicide, and one of the more controversial, was sexual orientation (Report of the Secretary's Task Force on Youth Suicide, 1989).

Suicidal behavior among homosexual youth : An overview.

In Volume 3 of the Report of the Secretary's Task Force on Youth Suicide, Gibson (1989) postulates that "Gay youth are 2 to 3 times more likely to attempt suicide than other young people and that they may comprise up to 30 percent of completed youth suicides(p.110)". Bell and Weinberg (1978), in their comprehensive study of homosexuals residing in the San Francisco Bay Area, found that homosexually oriented male adolescents and youths were more at risk for suicide attempts than heterosexually oriented male adolescents. In their random sample of youth, homosexual and heterosexual males were matched for age and education. Attempted suicide rates were 16 times higher among homosexual male adolescents under age 17 than heterosexual adolescents. For those under age 20, rates were 13 times higher in homosexual compared to heterosexual male youth. When those under 25 were compared, rates were 6 times higher in homosexual males (as cited in Tremblay, 1998). Other studies (D'Augelli & Hershberger, 1993; Hammelman, 1993; Harry, 1994; Remafedi, 1994; Remafedi, 1987a; Remafedi, 1987b; Remafedi, Farrow, & Deisher; 1991; Remafedi et al., 1998; Roesler & Deisher, 1972; Schneider, Farberow, & Kruks, 1989) have found consistently high rates of attempted suicide, in the range of 20% to 42% in self-identified volunteer samples of homosexual youth. However, where some authors such as Gibson (1989) speculate that gay youths are 2 to 3 times

more likely to attempt suicide than other young people, others (Shaffer, Fisher, Hicks, Parides, & Gould, 1995) have reported results from psychological autopsy studies show that the rate among completed suicides to be as low as 2.5%. The research addressing sexual orientation and suicide risk factors has been fraught with controversy. For example, Volume 3 of the Report of the Secretary's Task Force on Youth Suicide was initially suppressed by the Bush administration under pressure from right-wing groups and by conservatives in Congress. In 1991, the Secretary of Health and Human Services rescinded funding for The American Teen Study which was to study risk-taking behavior, including sexual behavior, of a national sample of 24,000 adolescents in grades 7-11 (Gardner & Wilcox, 1993). The cancellation of this study leaves us uncertain about current rates of suicide risks in the homosexual and bisexual population. The studies (Bradford, Ryan, & Rothblum, 1994; D'Augelli & Hershberger, 1993; Hammelman, 1993; Hershberger et al., 1996; Kourany, 1987; Remafedi, 1987a; Remafedi, 1987b; Remafedi et al., 1991; Rich, Fowler, Young, & Blenkush, 1986; Roesler & Deisher, 1972; Rotheram-Borus, Hunter, & Rosario, 1994; Proctor & Groze, 1994; Schneider et al., 1989; Shaffer et al., 1995) that addressed this topic used small, volunteer samples. However, in the past few years, there have been a handful of carefully designed, population-based, quantitative studies which begin to shed light on how many youth are homosexual or bisexual and on their disproportionate risks for suicide (Bagley & Tremblay, 1997; Remafedi et al.,1998; Resnick, Bearman, Blum et al., 1997; Safe Schools Coalition of Washington, 1995; Safe Schools Coalition of Washington, 1996).

This review examines the literature on suicidal behavior and sexual orientation among youth. The data presented above suggests why it is important to critically review

the risk factors of suicide among homosexual and bisexual youth. In the next section, a review of the research that has investigated the demographics of sexual orientation of youth in North America is presented.

Demography of Sexual Orientation in North America

Exact estimates of the prevalence of homosexuality is "subtle and shaded with gray, and that the answer to the question of how many homosexuals there are depends very much on what you mean by 'homosexual'" (Michael et al., 1994, p. 172). First, people often change their sexual behavior making it impossible to state that a particular set of behaviors defines a person as homosexual. Second, there is no one set of sexual desires or self-identification that uniquely defines homosexuality. Third, homosexual behavior is not easily measured. The history of persecution has a lasting effect both on what people are willing to say about their sexual behavior and on what they actually do. Nonetheless, many people have accepted the widely quoted figure from the Kinsey studies that 10 percent of Americans are homosexual.

The Kinsey studies (1948; as cited in Remafedi,1987b) are customarily reported as the first studies to provide prevalence estimates of various sexual behaviors. These studies reported that 37% of the total male population has at least some overt homosexual experience to the point of orgasm between adolescence and old age. Twenty-five percent of the male population has more than incidental homosexual experience or reactions for at least three years between the ages of 16 and 55. Ten percent of the males are more or less exclusively homosexual for at least three years between the ages of 16 and 55. Eight

percent of the males are exclusively homosexual for at least three years between the ages of 16 and 55. Four percent of the white males are exclusively homosexual throughout their lives (Kinsey, Pomeroy, & Martin, 1948; as cited in Remafedi, 1987b). These figures are much higher than comparable estimates in more recent studies (Binson et al., 1995; Michael et al., 1994; Remafedi et al., 1998; Remafedi et al., 1992).

Kinsey et al. (1948) estimated that about 13 percent of women had at least one homosexual experience in which they had an orgasm; and this is in comparison to the 37 percent figure for men (as cited in Michael et al., 1994, p.173).

More recent studies (Bearman, Jones, & Udry, 1989; Binson et al., 1995; Blum et al., 1989; Michael et al., 1994; Remafedi et al., 1998; Remafedi et al., 1992; Safe Schools Coalition of Washington, 1995) are population-based investigations designed to determine the prevalence of homosexuality. Depending on the methods, measurement, and definition of sexual orientation, the prevalence of reported homosexuality varied.

In a nationwide sample of adults aged 18 to 59, Michael and colleagues (1994) focused on three different aspects of homosexuality: being sexually attracted to persons of the same gender, having sex with persons of the same gender, and identifying oneself as a homosexual. The results of this study reported that about 4% of the women and 6% of the men said they were sexually attracted to individuals of the same gender (1994). About 2.7% of males reported having had same gender sex in the past year, and that 9% had same gender sex since puberty. In response to the question "Do you consider yourself heterosexual, homosexual, bisexual, or something else" about 1.4% of the women and 2.4% of the men said they thought of themselves as homosexual or bisexual (1994). Additionally, this study reports that more than 9% of men in the nation's twelve largest

cities identify themselves as gay, 3 to 4% of men living in the suburbs of these cities say that they are gay, and only 1% of men living in rural areas identify themselves in this way.

For women, the tendency to identify as gay was not so pronounced. Michael and colleagues (1994) found that 59 percent of their sample of women reported that lesbian sex was desirable but never acted on that desire. In addition, 13 percent of their sample did not consider themselves lesbians even though they both desire other women and have had sex with women. When they defined lesbians as women who had a female partner in the years since they turned 18 the percentage was as high as 6.2 percent in the largest cities and as low as 2.8 percent in rural areas.

Prevalence of homosexuality and bisexuality among youth.

Studies that have examined sexual orientation among youth have just recently started to be published. Most reports of youth sexual orientation of have been embedded in studies addressing adolescent health risks. Even though sexual orientation was not the central focus of most of these studies, the high rates of homosexuality and bisexuality indicate a need to ensure that research with adolescents acknowledges the existence of lesbians, gay men, and bisexual youth.

The Seattle Teen Health Risk Survey (Safe Schools Coalition of Washington, 1995) was a census-based sample; that is, it was offered to all high school students grades 9 through 12 in the Seattle Public Schools present on the day the survey was conducted. Altogether 8,406 students completed the survey with 91% characterizing themselves as

heterosexual. The other 9% either did not consider themselves heterosexual or stated that they were not sure. Of this 9%, only 1% identified themselves as gay or lesbian, 4% described themselves as bisexual, and 4% were not sure of their orientations (1996). These percentages are consistent with those reported by Michael and colleagues (1994) in their study of men and women.

The Massachusetts Youth Risk Behavior Survey surveyed 4,159 students in grades 9 through 12 attending 59 randomly selected schools across the state. Similar to the Seattle Teen Health Risk Survey this survey asked questions about sexual identity. However, unlike the Seattle Teen Health Risk Survey, the Massachusetts Youth Risk Behavior Survey also posed questions about sexual experience. The results of this survey report that: 2.6% of young women and 2.5% of young men surveyed said they had sexual contact with someone of their own gender, 23.4% [sic; 2.3 or 2.4%] of young women described themselves as bisexual or lesbian; 4.1% of young men described themselves as bisexual or gay; and, 4.4% of high school students statewide (and 6.4% of sexually experienced students) reported either having had sexual contact with someone of the same gender and/or considering themselves gay, lesbian or bisexual (Safe Schools Coalition of Washington, 1997, p.24).

The Vermont Youth Risk Behavior Survey, a third population-based study that specifically studied sexual demographics in youth, was conducted with 8th through 12th grade students. This study was a statewide weighted sample of 7,165 youth. These youths were not asked about their sexual orientation, although, they were asked the gender(s) of their sexual partners, if any. As stated in the Safe Schools Coalition Report (1997), "In comparison with the Massachusetts and Seattle data the usefulness of the Vermont data is

limited, however, worth sharing" (p.24). As mentioned previously in this paper, it is difficult to infer if those youth who reported same gender sex consider themselves to be homosexual or bisexual. In addition, it is difficult to determine if those who reported only having heterosexual sex define theselves as heterosexual or if those reporting abstinence are heterosexual, homosexual, or bisexual. The results of the Vermont Youth Risk Behavior Survey were as follows: 4% of 8th through 12th grade men reported having had at least one male sexual partner; 3% of 8th through 12th grade women reported having had at least one female sexual partner.

The prevalence estimates of these three school based studies differ from those offered by Kinsey (1948; as cited in Remafedi, 1987b). However, in another large population-based study (Remafedi et al, 1992) undertaken to specifically explore patterns of sexual orientation in a sample of 34,706 students grades 7 through 12, 10.7% of students were 'unsure' of their sexual orientation; 88.2% described themselves as predominately heterosexual; and 1.1% described themselves as bisexual or predominately homosexual. The reported prevalence of homosexual attractions (4.4%) exceeded homosexual fantasies (2.6%) or sexual behavior (1%). However, the proportion of boys reporting primarily homosexual attractions and behavior intent was 6.4% by age 18 and approximated Kinsey's projections of adult homosexuality. Similar to The Seattle Teen Health Risk Survey results of this study revealed that older adolescents were more likely than younger adolescents to report homosexual identities and attractions. Additionally, Remafedi and colleagues (1992) postulated that "the discrepancy between adolescents' reported sexual orientation and their attractions, fantasies, and behaviors may reflect a reluctance to be labeled as homosexual" (p.720). These findings illustrate some of the

complexities and difficulty in assigning sexual orientation labels to adolescents. As stated by Gonsiorek and colleagues (1995, p.47), "researching the 'true' prevalence of homosexuality is compromised by variable pressures on respondents against full disclosure of sexual behavior; widely varying ways to conceptualize sexual orientations, particularly whether behavior versus fantasy (attraction) versus both are used..." Research with adolescents will have further limitations, most likely in the direction of underestimation of same-sex orientation, because some adolescents are insufficiently knowledgeable about their sexual orientations to report accurately; instead, these are likely to describe themselves as normative, that is heterosexual.

It is impossible to provide a clear, definite answer to the prevalence of homosexuality among youth. The answer to the question of how many homosexual youths there are depends on how you define homosexual. It appears that approximately 4% of youth identify as being exclusively homosexual. However, it seems likely that an additional 6% of youth could be considered homosexual based upon self- report of same gender sexual desires and behaviors. In general, information about the sexual orientation of adolescents is sparse and that it is possible that recent studies underestimate the amount of homosexual activity that is taking place.

Given the size and scope of this population it is important to examine critically if homosexual and bisexual youth are at greater risk than heterosexual youth for suicide, suicide attempts, and suicidal ideations. Furthermore, this literature review investigates if the risk factors and predisposing conditions for suicidality differ by sexual orientation.

Methodological Issues in Research on Suicide and Gay, Lesbian, and Bisexual Youth

Suicide.

A major methodological limitation of this research centers on the lack of an acccepted nomenclature for fundamental terms such as "suicide attempt", "suicide ideation," and "lethality". These terms are often not operationally defined or are conceptualized differently across studies (Berman & Jobes, 1991; Davis & Sandoval, 1991; Gonsiorek et al., 1995; Muehrer, 1995). To assist in overcoming this problem, Meehan, Lamb, Saltzman, and O'Carroll (1992) suggest defining the term "suicide attempt" through a series of increasingly specific questions. For example, in their study of attempted suicide among young adults, they defined attempted suicide by asking if respondents had "attempted to take their own lives" rather than whether they had "attempted suicide"(1992). To determine lethality, they asked questions about the outcomes of reported attempts, that focused on injury, medical care received, and hospitalization.

Studies that pay careful attention to the definition and measurement of suicide variables will be highlighted in this review.

Sexual Orientaton.

Muehrer (1995) stated that "Research on attempted suicides among gay and lesbian youth must, of course, take place in the broader context of research on suicide

attempts among youth in general. Thus, limits to our knowledge about suicide attempts [completed suicides and suicidal ideations] among youth in general apply to gay and lesbian youth as well" (p.74). In addition, there are three methodological problems that have a large impact on research on suicide among gay, lesbian, and bisexual youth: (1) the heavy reliance on convenience sampling strategies, (2) use of autopsy reports , and (3) lack of consistency in the definition of homosexual orientation. Most of the studies that have examined suicide among gay, lesbian, and bisexual youth recruited their samples from convenience sources such as gay youth centers, treatment facilities, organizations, and publications. Samples were mainly composed of white males living in metropolitan areas. Furthermore, almost all of these studies relied on self-identified gay youth and self-report measures. Samples may not be representative of gay, lesbian, and bisexual youth in general, but, because adults and, especially, adolescents may keep their sexual orientation hidden, representative sampling of gays, lesbians, and bisexuals is extremely difficult in the current climate of American society (Remafedi, 1994).

Another impediment to obtaining accurate estimates of suicide rates among homosexual and bisexual youth is the use of autopsy reports. Sexual orientation is not indicated on death certificates or in hospital records so rates cannot be determined for gay men and lesbians in the same way that they are for identifiable groups such as women. However, an autopsy study by Rich and colleagues (1986), is continuously cited throughout the literature as refuting a higher rate of suicides for homosexuals as compared to heterosexuals. The difficulty with ascertaining sexual orientation from a death certificate is that data pertaining to sexual orientation has never been documented on the forms completed at the time of death. Furthermore interviews with a parent or sibling of

the deceased do not always provide accurate information as youth often have never disclosed their sexual orientation to those being questioned. Rich et al. (1986) reported a sample of 106 heterosexuals and 13 homosexuals. What we do not know from this study is how these individuals, if they were alive to tell us, would categorize themselves. Remafedi (1994), commenting on this study stated "since suicide attempts in homosexual persons have been found to be associated with nondisclosure of orientation, it is reasonable to expect that the 10 percent figure is the lowest possible estimate of the actual proportion of gay suicides in the San Diego cohort" (p.11).

An even more problematic area for research with gay, lesbian, and bisexual youth, is that conceptualizing "homosexuality" is fraught with difficulties. One difficulty may be confusion over distinctions between sexual behavior and sexual identity. Accordingly, rates of homosexual and bisexual orientation and/or sexual identity will be effected by how the researcher presents the questions designed to elicit this information. For example, a youth may have a same-sex sexual identification but engage in heterosexual behavior and feel attractions for both sexes, but in different ways. Additionally, various forms of sexual activity occur independent of one's attractions or identity, as a result of curiosity, peer or familial pressure, or sexual opportunity. For example, Remafedi and colleagues (1992) found that (1) homosexual sex is not the exclusive domain of adolescents who later identify as bisexual, lesbian, or gay; homosexual sex is reported by adolescents who later identify themselves as heterosexual, and (2) many youths report a same-sex identity without engaging in same-sex activity. As summarized by Savin-Williams (1995), "Bisexual, gay male, and lesbian adolescents exist; sometimes they have heterosexual sex, homosexual sex, both heterosexual and homosexual sex, or no sex. Sexual identity may

be clear or ambivalent..."(p.168). The lack of consensus about definitions of sexual terms and the lack of clarity about how homosexuality is measured makes comparison across studies extremely difficult.

Another obstacle in accurately assessing sexual orientation is the use of self-reports, most specifically verbal self-reports. For example, individuals must accurately appraise their own degree of same-sex interests. This issue is particularly difficult when measuring sexual orientation in adolescents, since sexual orientations may not be clear to them. Further, the persecution of gay men and women has a lasting effect both on what people are willing to say about their sexual behavior and on what they actually do. Finally, many youth have not developed the requisite language or cognitive abilities to describe their sexual feelings in ways that correspond to adult concepts of sexual orientation (Remafedi, 1987b) and this may result in their report not meaning the same thing as the researcher understands (Gonsiorek et al., 1995).

It is yet to be determined if these youth would be labeled truly homosexual. From a pragmatic health perspective, what is important is that there are a sizable minority of adolescents. who because of their homosexual behavior, or because of attendent feelings or alienation, may be at risk for medical and psychiatric morbidity and mortality (Remafedi, 1987b).

This section has attempted to provide an overview of some of the methodological shortcomings in research addressing the relationship between suicide and sexual orientation among adolescents. Despite the lack of consensus in the definition and measurement of key concepts, these and other problems do not negate the importance of attempting to study sexual orientation and its importance for suicide among youth.

The next chapter reviews the empirical literature related to sexual orientation and suicidality among youth in North America. First findings from general population-based studies are presented. Second, findings from studies which have assessed suicide rates in large samples of gay and lesbian youth are reported. Finally, findings from smaller volunteer samples of self-identified gay, lesbian, and bisexual youth are discussed.

CHAPTER II

Empirical Evidence of Suicidality: Comparison of Heterosexual, Homosexual, and Bisexual rates

This chapter presents findings from two sets of population-based studies. One set of studies embedded questions about sexual orientation and/or behavior in the larger investigation of health risk behaviors. Many of these studies did not analyze suicide rates or specific risk factors by sexual orientation. A second set of population-based studies focused on examining suicide rates across groups of heterosexual, gay, lesbian, and bisexual youth. These studies did anlayze suicidality in relation to sexual orientation.

Population-Based Studies

General population.

Public health officials, mental health practitioners, educators, and the public at large have been concerned over the past decade by increasing rates of suicide among adolescents. There have been a number of recent longitudinal studies which have examined rates for suicides, suicide attempts, and suicidal ideations (see Table 1). This section will focus on reviewing the findings from these population-based studies.

The National Longitudinal Adolescent Health Study referred to as the Add Health study (Resnick et al., 1997) was developed to provide comprehensive information about the factors which influence adolescent health and health risk behaviors. This study was undertaken in response to a mandate by the US Congress. The National Institute of Child Health and Human Development (NICHD) and 17 other Federal Offices and Institutes funded the study (Blum & Rinehart, 1997). The Add Health was a major comprehensive study conducted in two phases. In the first phase, some 90,000 students in grades 7 through 12 attending 145 schools around the United States completed brief questionnaires about their lives. The surveys included questions about suicide attempts, suicidal ideations, and same-sex attractions and behaviors. In the second phase over 20,000 in-home interviews of students were conducted between April and December of 1995 (Wave I). All data were collected on lap-top computers. A follow-up (Wave II) of 15,000 adolescents, interviewed again at home, was conducted between April and August of 1996. Eighteen thousand parent interviews were completed as part of Wave I (Blum & Rinehart, 1997). Additionally, in the first year of the study, administrators from the participating school completed questionnaires dealing with school policies and procedures, teacher characteristics, health service provision or referral, and study body characteristics.

In 1996, school information was updated in a telephone interview with school officials (Blum & Rinehart, 1997).

Analysis of Wave I responses revealed that 87.4% of adolescents indicated that they had neither suicidal thoughts nor attempts over the past year. A total of 10.2% of girls and 7.5% of boys reported having considered suicide without having attempted it over the past year, while 3.6% of all adolescents reported suicide attempts. Hispanic and Native American teens, females, and teens living in rural areas were found to be most at risk for suicide attempts (Blum & Rinehart, 1997).

The Add Health research team further examined individual factors believed to be generally important for health and well being. Among 9th through 12th graders, emotional distress tended to be higher and considered a risk factor for poor emotional health among those reporting same-sex attraction or behavior. However, same-sex attraction was not found to be a risk factor for suicidal thoughts and attempts among 7 through 12 graders.

The Add Health Study is one of the strongest studies to date to investigate adolescent health and morbidity. What separates this study from most other studies is the comprehensive design, measures, and methods utilized to report results. A major strength of this study is that it is designed to encourage ongoing analyses of its data set. The findings presented describe the first results from the Add Health study. Because of the volume of data collected, a complete analysis of the survey is expected to take a decade or more.

A second noteworthy study to investigate the scope of health problems among adolescents was conducted by the Minnesota Department for Health and the University of Minnesota Adolescent Health Program, referred to as The Adolescent Health Survey. As

part of that effort, a large scale adolescent health survey was undertaken in 1986-87 to collect comprehensive information from over 36,000 Minnesota public school youths in grades 7 through 12 (Blum et al., 1989). The Adolescent Health Survey contained 148 questions pertaining to demographic characteristics, family, school and peer relationships, health care utilization, sexuality, antisocial behaviors, emotional stress, substance use and nutrition.

A strength of this study was in their sample selection. The survey employed a multi-stage stratified cluster design for selecting schools in which to administer the survey. All public school districts in the state were sorted and stratified by size. The schools targeted for surveying were selected by a random procedure within the strata (Blum et al. 1989). The characteristics of the sample were quite similar to those for the youth population in Minnesota.

Fourteen percent of females and seven percent of males surveyed reported ever having attempted suicide. In the one-year period immediately preceding the survey, three percent of male respondents and six percent of females attempted suicide. Additionally, they found that attempted suicide increases with age with six percent of males and nine percent of females in 7th grade reporting a suicide attempt compared to eight percent and 18 percent in 12th grade respectively. One-third of girls and one-fifth of boys report suicidal thoughts in the month prior to the survey with nearly two percent of both boys and girls stating they would kill themselves if they had the chance. Of those that indicated they would kill themselves if they had the chance, over one-third had previously attempted suicide.

This study did not provide figures for rates of suicidality based upon sexual orientation. However, it is one of the few studies to have inquired from a population-based sample about sexual orientation among adolescents. Different from the Add Health Study, this survey went beyond a dichotomous yes/no variable response format when inquiring about sexual attraction/behavior. This survey used five items pertaining to different dimensions of sexual fantasy, sexual behaviors with males and females, sexual attractions and intended behaviors, and sexual orientation/self-identification in order to categorize sexual orientation from the subjects' own perspective.

Remafedi and colleagues (1998) selected subjects from the 1987 Adolescent Health Survey database to specifically examine the relationship between sexual orientation and suicide risk in a population-based sample of adolescents. Two hundred and twelve males and 182 females who described themselves as bisexual/homosexual were compared with 336 gender-matched heterosexual respondents on three outcome measures: suicidal ideation, intent, and self-reported attempts. Suicide attempts were reported by 28.1% of bisexual/homosexual males, 20.5% of bisexual/homosexual females, 14.5% of heterosexual females, and 4.2% of heterosexual males. For males, but not females, bisexual/homosexual orientation was associated with suicidal intent.

The finding that male bisexuality/homosexuality was associated with a greater than sevenfold increased odds of a suicide attempt exceeded the projections mentioned earlier in this paper by Gibson (1989) in the US Department of Health and Human Services report. However, where this study provided evidence of a strong association between suicide risk and bisexuality or homosexuality in males, bisexuality/homosexuality was not significantly associated with suicide risk in young women.

Despite its limitations in generalizability, this is the first study to examine the relationship between sexual orientation and suicide risk in a population-based sample of male and female adolescents. Overall, the data from this study provide the strongest evidence of a strong association between suicide risk and bisexuality or homosexuality in male adolescents.

In addition to the research conducted in the state of Minnesota, in 1995 three quantitative studies designed to shed light on the question of how many students are gay, lesbian, or bisexual and on their disproportionate suicide risks were conducted. These three studies are versions of the 1995 Youth Risk Behavior Survey (YRBS) from the Federal Centers for Disease Control and Prevention (CDC, 1996). All three are comprehensive surveys addressing a variety of issues critical to teen health and safety (Safe Schools Coalition of Washington, 1997). These studies have been described in more detail in Chapter One.

The first of these studies is the 1995 Seattle Teen Health Risk Survey (SEA). Of the total 99 items in the survey, one question asked students their sexual orientation and another asked them if they had been harassed or attacked due to their perceived orientation.

The second study is the 1995 Massachusetts Youth Risk Behavior Survey (MA). The Massachusetts survey asked about both sexual identity and sexual experience. The third study is the 1995 Vermont Youth Risk Behavior Survey (VT). The Vermont survey participants were not asked their sexual orientations but were asked about the gender(s) of their partners, if any.

In the Seattle Study (SEA) students who described themselves as gay, lesbian or bisexual reported for the 12 months preceding the survey to be twice as likely as heterosexual students to report having seriously considered suicide and to have made a suicide plan, three times as likely to report having attempted suicide, and over four times as likely to report that they made a serious enough attempt to require medical treatment.

Results of the Massachusetts Survey (MA) report that gay, lesbian, and bisexual students, and the ones not sure about their sexual orientation, were over four times more likely to have attempted suicide in the past year than heterosexual-identified students. Similar results were found from the Vermont Study (VT) with gay, lesbian and bisexual students reporting to be 2.5 times more likely to have attempted suicide in the past year than heterosexual-identified students and over 4 times more likely to have made a suicide attempt requiring medical attention (Safe Schools Coalition of Washington, 1997, p. 26).

It is important to consider when evaluating these results that not all adolescents are ready to acknowledge their homosexuality on a questionnaire; some are not yet able to acknowledge this to themselves, much less to anyone else. Furthermore, the suicide rates among gay, lesbian and bisexual percentages may be under-estimated because these students are at high risk for truancy and dropping out of school. Therefore, there is a greater probability that gay, lesbian, and bisexual adolescents (compared to heterosexual adolescents) were not in school when the questionnaire was being given. Even when taking these concerns into consideration, the findings from these three school-based studies suggest that rates of suicidality among heterosexual and homosexual adolescents warrant concern.

Gay and lesbian populations.

A more recent study of suicidality among gay and bisexual males was conducted by Bagley and Tremblay (1997) using a stratified random sample of 750 males aged 18 to 27 in Calgary, Canada. Young men were placed into categories based upon recent sexual activity. Celibate males were divided in two categories, predominately homosexual and predominately heterosexual, and produced a 12.7 per cent estimate for males classified homosexual and/or bisexual on the basis of self-identification (11.1 per cent) and/or current homosexual activity (9.2 per cent). A total of 115 of the 750 males (15.3 percent) reported having had consenting homosexual experiences at some point since the age of twelve and/or self-identified at the time of the survey. The results from this study suggests that homosexually oriented male youth may account for more than half of male youth suicide attempters, reflecting a 14-times greater risk for a suicide attempt.

Bagley and Tremblay's study has several strengths. First, it used a randomly generated community sample. They also did not include in their sample youth leading relatively unstable lives. For example, Bagley and Tremblay excluded institutionalized youth at high risk for life-threatening suicide attempts. There are some limitations of this study which need to be addressed. Of the 750 persons that participated in this study only 82 were identified as either active homosexual (32/750), active bisexual (37/750), or celibate homosexual (13/750). As can be readily seen, the sample within these specific categories seems rather small as compared with the active heterosexual (544/750) and celibate heterosexual (124/750) categories. Second, this study differed from the

previously mentioned studies in this paper in that the sample was exclusively male, the age range for participants was older (18-27), and they resided in Canada not the United States.

Another study which provides similar conclusions about the high risk for suicide among older homosexual adolescents and young adults was conducted by Bradford, Ryan, and Rothblum in 1984 to 1985 (Bradford et al., 1994). In contrast to the other studies discussed, the purpose of this research was to gain information about the health and mental health care needs of lesbians as compared with heterosexual women. In this study, 1,925 lesbians from all 50 U.S. states completed the National Lesbian Health Care Survey. Eighty-eight percent of the sample were White, 6% were African American, and 4% were Latina. Very small numbers of Asian Americans and Native Americans were also included. These percentages were roughly similar to those in the census data, but the lesbian sample had only half the percentage of African Americans, compared with census data. The age range of the sample was 17-80 years; 8.9% were between the ages of 17-24 and 48.4% between 25-34 years of age. Since it was impossible to devise a strategy for reaching a random sample of a hidden population, survey respondents included lesbians who could be reached and who were willing to participate in the project. The survey participants were recruited through gay health and professional organizations, mental health practitioners, and by means of personal networks across the United States. Despite its limited generalizability, this is the most comprehensive study on U.S. lesbians to date.

The National Lesbian Health Care Survey studied six mental health components: (a) suicide ideation and attempts, (b) depression and anxiety, (c) current stressors, (d) physical and sexual abuse, (e) alcohol and drug abuse, and (f) eating disorders. About 25% of the women under 24 years of age had made a suicide attempt with only 41%

stating they had never contemplated taking their own life. Among the sample as a whole, 18% had attempted suicide, 21% had thoughts about suicide sometimes or often. Less than half the sample (43%) indicated that they never had thoughts about suicide. This study did not assess lesbians under the age of 17. The results however, do indicate higher percentages of suicidal thoughts and attempts among the youngest age group. Given these high rates it seems likely that rates for younger adolescents would also be high.

The studies presented obtained their findings from population-based samples. As summarized in Table 1, these population-based studies provide evidence of elevated rates of suicidality among gay, lesbian, and bisexual youth (see Table 1). These studies report that homosexual male youth are three to seven times more likely to attempt suicide than heterosexual male youth. The rates of suicide attempts for lesbian youth ranged from 17.7 % to 24% in comparison with 5.1% to 14.5% for female youth in general.

Table 1

Evidence of Suicidality from Population-based Studies

Study/Year	N	Age/Grade	% Attempts Heterosexual M	% Attempts Heterosexual F	% Attempts Homosexual M	% Attempts Homosexual F	% Ideations Heterosexual M	% Ideations Heterosexual F	% Ideations Homosexual M	% Ideations Homosexual F
Bagley & Tremblay (1997)	750	18-27	2.8 Active 17.7 Celibate		9.4 Active 46.1 Celibate				9.4 Active 46.1 Celibate	
Bell & Weinberg (1978)	3000+	Age 25 or less	2.3 White 2.0 Black	8 White 7.4 Black	14.2 White 16.8 Black	17.7 White 13.8 Black				
Blum, McKay Resnick et al (1989)	36,284	7th - 12th	7	14			20a	33a		
Bradford, Ryan, Rothblum (1994)	1,900+b	17 - 24				24				27c
MA Youth Risk Behavior Survey (1995)d	4,159	9th - 12th			4x more likely than Heterosexual f					
Remfedt, French Story et al (1998)e	212 lesbian 182 gay men 336 Heterosexual	11th - 12th	4.2	14.5	28.1	20.5				
Resnick, Bearman, Blum, et al (1997)	90,000+	7th - 12th	2.1	5.1			7.5f	10.2f		
Seattle Teen Health Risk Survey (1995)d	8,406	9th - 12th	6.7 males and females f		20.6 males and females f		16.7 males and females f		34.4 males and females f	
Vermont Youth Risk Behavior Survey (1995)d	7,165	8th - 12th			Approx. 3 times more likely than Heterosexual f					

Note: Empty cells indicate data are unavailable, unreported , or inapplicable

a. Rates reported for 1 month prior to study
b. Rates reported for gay females
c. Reported as sometimes or often
d. Studies referenced as Safe Schools Coalition of Washington (1995; 1997)
e. Sample obtained from Blum, McKay, Resnick et al. (1997)

f. Reported for the past year prior to survey

Volunteer Samples of Self-Identified Gay, Lesbian, and Bisexual youth

As shown in Table 2, estimates of suicide attempts and suicide ideations for gay, lesbian, and bisexual youth vary among the studies presented in this section (see Table 2). However, since 1972 (Roesher & Deisher, 1972) studies of gay and bisexual male youth, with or without lesbian and bisexual females, have consistently reported high attempted suicide rates for these youths.

The studies reported in this section all used volunteer samples of self-identified gay, lesbian, and bisexual youth. Most studies rely upon clinicians' observations (Gibson, 1989), retrospective reports of gay men (Hammelman, 1993; Schneider et al., 1989), samples drawn from gay youth community and social service agencies (D'Augelli & Hershberger, 1993; Hershberger et al., 1996; Proctor & Groze, 1994; Remafedi, 1987a; Remafedi et al., 1991; Roesler & Deisher, 1972; Rotheram-Borus et al., 1994), and interviews with psychiatrists working with adolescents (Kourany, 1994).

The earliest study attempting to assess the mental health needs of gay youths was conducted by Roesler and Deisher (1972). They interviewed 60 young men ages 16 to 22, the mean age being 20, all of whom had engaged in homosexual acts to orgasm at age 16 or older. The intention of the study was to investigate the gradual development of boys into members of the homosexual subculture and to identify milestones at which physicians or counselors might be called on to intervene.

The sample was recruited through acquaintances who knew the young men, at social settings frequented by gay persons, and youths who were referred to the study after

being rejected by the selective service for homosexuality. Of the 60 subjects, about one-third considered themselves bisexual. Interviewers asked the young men questions about sexual experience, sexual identity, coming-out, socialization patterns, and emotional problems. Questions regarding depression and suicidal thoughts revealed that 19 of the 60 subjects (31%) made what they considered to be a significant attempt on their lives. Seven young men reported multiple suicide attempts.

Two other studies which used similar recruitment methods were conducted by Remafedi (1987a) and Remafedi and colleagues (1991). The intent of the first study (Remafedi, 1987a) was to identify the current psychological, social, and health-related problems of gay adolescents. The subjects were twenty-nine 15 through 19 year old (mean age 18.3 years) young men, who were self-identified as homosexual (79%) or bisexual (21%). The sample was predominately white, Christian, and middle class, reflecting the general demographics of the urban Minnesota population where the study was conducted (Remafedi, 1987a). All subjects participated in a structured interview where specific questions included inquiries about suicide attempts and ideations. All but one subject admitted to contemplating suicide at least some time in their lives and 34% had made a suicide attempt.

In a later study with a larger sample Remafedi et al.(1991) studied risk factors for suicide attempts among bisexual and homosexual male youth. Subjects were 137 gay and bisexual males, 14 through 21 years of age, from the upper Midwest and Pacific Northwest. The ethnic/racial composition of the subjects was more diverse than in the earlier study with 82% being White, 13% African American, 4% Hispanic, and 1% Asian. Subjects in this study identified as being Catholic (20%), Protestant (24%), Other (29%),

and None (27%). The findings from this study supported the earlier findings in that there was a significantly high rate of reported suicide attempts. Thirty percent of subjects reported at least one suicide attempt, and almost half of the attempters reported more than one attempt. The mean age at the time of suicide attempts was 15.5 years. Twenty-one percent of the suicide attempts resulted in a medical or psychiatric hospitalization.

D'Augelli and Hershberger (1993) studied the personal challenges and response to stress of 194 lesbian, gay, and bisexual youth aged 15 to 21 who attended programs in 14 community centers located in metropolitan areas. In the final sample, 75% said they were lesbian or gay, 19% said they were bisexual, but mostly lesbian or gay; and 6% said they were bisexual and equally heterosexual and lesbian/gay. Two thirds (66%) of the sample were White, 14% were African American, 5% Asian American, 6% Hispanic American, and 4% American Indian.

Survey questions centered around four domains: (a) sexual orientation and behavior, (b) social aspects of sexual orientation, (c) disclosure of sexual orientation within the family, and (d) mental health problems. In presenting the data for suicidality among their sample, D'Augelli and Hershberger compared nonattempters (NATT) with attempters (ATT) on the above mentioned four domains. Their findings report that only 40% of their sample said they had never thought about killing themselves; 30% said rarely, 21% said sometimes; and 8% said they often thought about suicide. No differences between males and females were found. Of the total sample of 194 youth, 42% had made a past suicide attempt and of the attempters, the number of suicide tries ranged from one to fifteen with no sex differences.

Other studies of youths recruited from community agencies or social organizations have been conducted by Hammelmann (1993), Proctor and Groze (1994), Rotheram-Borus et al. (1994), and Schneider et al. (1989). In Hammelmann's study there were 20 female (42%) and 28 (58%) male respondents. The age of respondents was somewhat higher than in other studies presented in this section, with ages ranging from 15 to 32. Similar to other studies discussed throughout this section, there was a predominance of White respondents (96%) with the remaining 4% of respondents being African American.

The findings from this study report that 29% of the respondents had attempted suicide. Of those who had attempted suicide, 50% were male and 50% were female. Forty-eight percent of the respondents had seriously considered suicide. Of those who had seriously considered suicide, 43% were male and 57% were female (Hammelman, 1993).

Similar to Hammelman's study, which included both males and females in the sample, Proctor and Groze (1994) obtained a sample of 221 self-identified gay, lesbian, and bisexual youth who attended youth groups across the United States and Canada. The suicide attempt rate reported from this study is one of the highest reported from any of the studies reviewed for this paper. The findings from this study report that 40.3% of their sample of 221 self-identified gay, lesbian, and bisexual youth had attempted suicide and 25.8% had seriously thought about it at least once.

Two other studies which investigated suicidal behavior in adolescent and young adult gay men were conducted by Rotheram-Borus et al. (1994) and Schneider et al. (1989). Rotheram-Borus and colleagues' (1994) study differs from the other studies in this section in that the sample was predominately low income minorities: 51% Hispanic, 30% African American, 12% White, and 7% Other. Rotheram-Borus and colleagues (1994)

examined suicidality, stress, and gay-related stress among a consecutive series of 131 minority youth, aged 14 to 19, seeking services at a nonresidential, community-based agency providing recreational and social services for gay and lesbian adolescents in New York City.

The attempted suicide rates from this study were similar to two previously mentioned studies (D'Augelli & Hershberger, 1993; Proctor & Groze, 1994) that included both African American and Hispanics in their samples. Rotheram-Borus and colleagues (1994) reported a suicidal attempt rate of 39%, with D'Augelli and Hershberger (1993) reporting a 42% rate, and Proctor and Groze (1994) reporting a rate of 40%. Rotheram-Borus and colleagues (1994) also reported that more than one-half of those that had attempted suicide had made more than one attempt.

Schneider and colleagues (1989) also observed a trend toward greater suicidology among their small sample (Black 4/108, Latino 16/108) of racial/ethnic minority gay men, particularly among Latino gay men. Despite the limitation of these findings from such a small sample, these results in conjunction with Rotherman-Borus et al.'s (1994) are significantly high and differ from the general population. For example, suicide attempt rates in the current sample are four times higher (39% vs. 9%) than rates among Hispanic males in high school surveys conducted by the Centers for Disease Control (1991; personal communication with Laura Kann, CDC, February 2, 1993; as cited in Rotheram-Borus et al., 1994).

Schneider and colleagues (1989) examined suicidal ideation and attempts in self-identified gay youths, aged 16 to 24, attending supportive and social college and community groups. This study reported a smaller percentage of suicide attempts (20%)

than in other studies reviewed in this section. However, the 20% rate reported is still significantly higher than the national average. The reported rate of 55% for suicidal ideation was similar to other studies reviewed.

Schneider and colleagues (1989) also reported that the mean age at the time of the first suicide attempt was 16.3 years; the youngest age at first attempt was 12. Twelve attempters had made a single attempt; 10 reported 2 to 14 attempts. These multiple attempt rates are similar to those of Remafedi and colleagues (1991) that about half of those who made suicide attempts went on to make another attempt.

All studies cited in this section reported high levels of suicide attempts and suicide ideations among gay, lesbian, and bisexual youth (see Tables 1 and 2). The strongest evidence against an elevated suicide attempt rate among this population comes from autopsy studies which systematically examine the lives of youths who have recently committed suicide. Two studies, Rich et al. (1986) and Shaffer et al. (1995), are cited by those who) dismiss the idea that gay youth are more at risk for suicide than heterosexual youth (Mosciski, Muerer, Potter, & Maris, 1995; Muehrer, 1995. However, even Rich et al. (1986) recognized the limitations of their analysis in their study by stating, "A sample of 13 is hardly adequate to justify highly sophisticated statistical analysis or any major conclusions" (p.453). Shaffer and colleagues' study had an even smaller sample, with only 3 males out of 120 suicides and 145 controls deemed to meet the criteria for homosexuality set by the researchers, either revealing their gay identity to others (one case), or having had same-gender sex. As noted earlier, sexual orientation is not indicated on death certificates so that rates cannot be determined for gay men and lesbians in the same way they are for more easily identified groups. Similar to the other studies discussed

in this section, sampling difficulties have posed difficult challenges because many gay men and lesbians keep their sexual orientation secret from individuals and public records. Therefore the findings from these psychological autopsy reports should be interpreted with caution.

The studies using volunteer samples of self-identified gay, lesbian, and bisexual youth report that 20% to 42% of these male youth have attempted suicide. Of the eight studies presented in this section, only three included homosexual or bisexual females in their samples. These studies report a suicide attempt rate of 29%, 40.3%, and 42% for the small percentage of females included in the samples. Suicidal ideations were reported by 37% to 99% of homosexual male youths, and 25.8% to 60% of homosexual female youth.

Chapter Summary

The empirical data clearly show that youths are at high risk for attempted suicide rates and suicidal ideation, and that gay, lesbian, and bisexual youth are at much greater risk for suicide than heterosexual youth (see Table 1 and Table 2). The highest suicide attempt rates were obtained from the volunteer samples of self-identified gay, lesbian, and bisexual youth (see Table 2). These suicide attempt rates ranged from 20% to 42%, with an average reported rate of 33% for all studies combined. The rates of suicide attempts reported from the population-based studies for gay, lesbian, and bisexual youth on average were not as high as from the studies using volunteer samples of self-identified gay youth.

However, the rates of suicidality for gay and bisexual youth obtained from population-based studies did support the finding that these youth at minimum are 3 to 4 times more likely to attempt suicide than heterosexual youth.

There are several factors which need to be considered when making meaningful comparisons between the results of the population-based studies with those that used volunteer samples of self-identified gay youth. These factors seem likely to effect the differences found between the rates of suicidality reported. First, adolescents may not be comfortable with acknowledging to others a gay, lesbian, or bisexual identity, especially, if the questionnaire is being administered in a school setting where peers and school administrators have openly expressed anti-gay attitudes. Second, homosexual youth may not be ready to self-label as such even to themselves. Given these factors, concealment will be a problem in research with gay, lesbian, and bisexual youth and most likely will result in underestimation of homosexuality and rates of suicidality. Third, it may be speculated that the rates for suicide attempts would be inflated among the volunteer samples of self-identified gay youth if the estimates derived from clinical samples. Although most of the studies reviewed used volunteer samples obtained from nonclinical or community settings, these visible gay youth may experience less suicidality than gay, lesbian, and bisexual youth that are more socially alienated and isolated. However, a question remains as to how comparable sexual-minority youth who particiapte in youth groups or volunteer to participate in research are to those who do not. In conclusion, despite the differences in rates across the studies, all suggest higher risk for suicidality among gay, lesbian, and bisexual youth.

Our knowledge of suicide among gay, lesbian, and bisexual youth would not be complete without an examination of risk factors. The purpose of the following section is to review the literature regarding contributing factors to serious attempts or considerations of suicide for homosexual, lesbian, and bisexual youth.

Table 2

Evidence of Suicidality from Volunteer Samples of Self-Identified Gay, Lesbian, and Bisexual Youth

			% Attempts Homosexual		%Ideations Homosexual	
Study/Year	N	Age/Grade	M	F	M	F
D'Augelli & Hershberger (1993)	142 males 52 female	15-21	42	42	60	60
Hammelman (1994)	28 males 20 females	15-32	29 of sample		48 of sample	
Proctor & Groze (1994)	159 males 62 females	to age 21	40.3 of sample		25.8 of sample	
Remafedi (1987a)	29 males	15-19	34		99 (28/29)	
Remafedi et al. (1991)	137 males	14-21	30			
Roesler & Deisher (1972)	60 males	16-22	31			
Rotheram-Borus, Hunter & Rosario (1994)	131 males	14-19	39		37	
Schneider et al. (1989)	108 males	16-24	20		55	

Note: Empty cells indicate data are unavailable, unreported, not applicable

Chapter III

Empirical Evidence for Suicidal Risk Factors for Homosexual and Bisexual Youth: A Comparison with Heterosexual Youth

The Secretary's Task Force on Youth Suicide (Gibson,1989) concluded "gay young people face the same risk factors for suicidal behavior that effect other youth. These include family problems, breaking up with a lover, social isolation, school failure, and identity conflicts. However, these factors assume greater importance when the youth has a gay or lesbian orientation" (p.125). Additionally, gay and lesbian youth seem to experience unique stressors in their lives that differentiate them from their heterosexual counterparts. This section reviews the research on risk factors for suicide behavior among gay, lesbian, and bisexual youth. Despite the paucity of research in this area, studies have identified several contributing factors associated with gay, lesbian, and bisexual youth suicide including victimization, substance abuse, gender non-conformity, young age at time of gay identity formation, religiosity, interrupted social ties/social isolation, and suicidology among family members.

Victimization

Among the most common risk factors identified in empirical studies and clinical reports of lesbian, gay male, and bisexual youths are verbal and physical abuse.

Population-based studies and studies drawing upon volunteer samples are reviewed separately.

Population-based studies.

The three school-based studies discussed in the review of suicide prevalence investigation (Seattle Teen Study; Massachusetts Youth Risk Behavior Survey; Vermont Youth Risk Behavior Survey) also examined harassment and violence in schools. With few exceptions, the findings from these reports confirmed the premise of the Safe Schools Project: "schools can be dangerous places for youth of all sexual orientation, and especially for those who are gay, lesbian, or bisexual or who are perceived to be sexual minorities (1996, p.11)". Only the Seattle Study specifically inquired about anti-gay harassment and violence and linked this type of violence to suicidality. The Massachusetts and the Vermont studies examined the extent of physical and sexual abuse experienced by gay, lesbian, and bisexual youth. Gay, lesbian, and bisexual youth were twice as likely to report having been in a physical fight in the past year, and were two to three times as likely to report ever having been forced/pressured into having sexual intercourse-not necessarily at school.

In the Seattle Study, 8% of all respondents (6% heterosexual and 34% gay, lesbian, and bisexual students) reported that they experienced offensive comments or physical attacks because someone thought they were sexual minorities. Thus, about one in three gay, lesbian or bisexual students reported having been harassed or attacked because

of their sexual orientation. This is over five times the percentage of heterosexual students who report being similarly harassed. Students who described themselves as gay, lesbian, or bisexual were 75% more likely than their heterosexual peers to report having been threatened or injured by someone with a weapon at school in the past year, and nearly three times as likely as heterosexual youth to report having been injured in a fight in the past year severely enough to have required treatment by a nurse or doctor.

The association between suicidology and being a target of harassment based on perceived sexual orientation differed between these groups. For example, 33.2% of self-identified heterosexual youth who were perceived by peers as homosexual and experienced verbal or physical harrassment seriously considered suicide during the 12 months preceding the survey. Approximately 45% of gay, lesbian, and bisexual youth who experienced verbal or physical harrassment because of their perceived sexual orientation seriously considered suicide in the year before the survey. These results can be compared with the rates reported for "not targeted" heterosexual (15.5%) and homosexual youth (29.8). These same groups were compared for suicide attempt rates. Comparisons across groups revealed that 5.7% of heterosexual not targeted youth, 20.5% of heterosexual targeted youth, 19.1% of not targeted homosexual youth, and 20.3% of targeted homosexual youth attempted suicide at least once in the 12 months prior to completing the survey. Among those who attempted suicide, 1.7% of the heterosexual not targeted youth, 8.6% of the targeted heterosexual youth, 7.8% of the not targeted homosexual, and 9.6% of the targeted homosexual youth were treated by a doctor or nurse.

Volunteer samples of self-identified gay, lesbian, and bisexual youth.

Hershberger and colleagues (1996), Hunter (1990), and Schneider and colleagues (1989) all found that physical abuse contributed to suicide risk in their samples of self-identified gay youth. In a sample of 142 gay men and 52 lesbians, aged 15 to 21, Hershberger and colleagues found that victimization and social rejection distinguished suicide attempters from nonattempters. Schneider and colleagues (1989) also compared the differences between suicide attempters and nonattempters in a sample of 108 gay men, aged 16 to 24, who attended gay rap groups or gay college organizations. Paternal alcoholism and physical abuse were found to occur more frequently in the backgrounds of those gay male youths who reported suicidal ideation in adolescence.

In the strongest study of its kind, Hunter (1990) documented a direct link between violent assaults toward lesbian and gay male youths and suicidal behavior. Data were obtained by reviewing charts for the first 500 youths seeking services in 1988 at the Hetrick-Martin Institute of New York, a community agency providing services for gay and lesbian teens and their families. The sample included both younger age adolescents (14 to 21), was predominately minority (35% African American, 46% Latino), and included both males and females. Forty percent (201 of 500) of the youths reported that they had experienced violent physical attacks. Of those reporting violent physical assaults, 46% reported that the assault was gay-related; 61% of the gay-related violence occurred in the family. Suicidal ideation was documented for 44% of those experiencing violent assaults. Approximately 41% of the females and 34% of the males reporting violent assaults had tried to kill themselves.

In summary, the results of these studies demonstrate that victimization, most specifically physical abuse, can be a contributing factor to suicide attempts and ideation by gay, lesbian, and bisexual youth. The victimization of lesbian, gay, and bisexual youth is not restricted to one particular social or community context. Rather, verbal abuse and physical assault occur in the family, school, and broader community environments of these young people. Whereas members of other stigmatized groups find solace from prejudice and victimization from their families in their homes, many youths in the studies presented in this section reported rejection and abuse by immediate family members because of their sexual orientation.

Social Isolation/Interrupted Social Ties

Durkheim's sociological theory suggests that individuals who experience social isolation and are denied full participation in society become progressively more isolated and alienated, and thus are more prone to suicide. The social isolation and alienation that youth in general experience can be overwhelming. However, gay, lesbian, and bisexual youths encounter a host of stressors related to their stigmatized sexual orientation beyond those encountered by heterosexual youth. This section presents the findings from studies that investigated the association between social isolation/interrupted social ties and suicidology among North American youth. The first two population-based studies reviewed in this section provide general population estimates without reference to sexual

orientation. Thereafter, emphasis is placed on comparisons between heterosexual and homosexual youth.

Population-based studies.

Blum and colleagues (1989) found of their sample of 36,284 students nearly 80.3% of students live in two-parent households, 16.8% in single-parent households, and 2.9% live either with another adult family member or in a foster-care arrangement. Nearly 90% of adolescents reported that their parents care about them "quite a bit" or "very much".

Blum and Rinehart (1997), the National Longitudinal Study of Adolescent Health, also reported that perceived caring and connection to others is important as protective factors against major areas of adolescent morbidity. With notable consistency across the domains of risk, the role of parents, family, and school in the health of adolescents was evident. More specifically, parent/family connectiveness and school connectiveness were reported as protective factors against suicidal thoughts and attempts for students in grades 7 through 12.

Only one population-based study directly investigated social isolation among gay, lesbian, and bisexual youth. In the Seattle Study, 9.7% of gay, lesbian, and bisexual teens said they could not think of any adult that really cares about them as compared to 2.9% of heterosexual teens in this study. These gay, lesbian, and bisexual teens were over three times as likely as their heterosexual peers to report feeling isolated and alienated from their parents and other adults in general. The link between social isolation and suicidality could

not be ascertained from the reported findings. However, several researchers have documented that social isolation is one of the more reliable correlates of suicide within the general population (cited in Harry, 1994).

Most of the research investigating social isolation and alienation among gay, lesbian, and bisexual youths used volunteer samples of self-identified gay teens. Following is a review of studies that examined the relationship between alienation and risk factors for suicidology among sexual minority youths.

Volunteer samples of self-identified gay, lesbian, and bisexual youth.

Throughout the literature reviewed in this section, there is attention drawn to the disrupted relations between gay, lesbian, and bisexual youths and their families of origin. However, Remafedi (1987a), Rotheram-Borus, Rosario, Meyer-Bahlburg et al. (1994), and Uribe and Harbeck (1992) were the only three studies to examine the living arrangements of their gay youth participants. Remafedi (1987a) reported that only 10 of 29 of his subjects resided with parents. The remaining 19 subjects cohabited with friends (9/19), other roommates (6/19), siblings (2/19), or male lovers (2/19). Approximately half of the subjects had run away from home at least once, and nearly half of these had done so repeatedly. Of this sample, all but one subject admitted to contemplating suicide at some time in their lives, 34% attempted suicide, and two of these had made multiple attempts.

Rotheram-Borus, Rosario, Meyer-Bahlburg et al. (1994) examined lifetime and current sexual and substance use behaviors among 131 predominately Hispanic and Black

gay and bisexual adolescent males in New York City. This study reported that 72% of the gay and bisexual male sample were currently living at home with either one or both parents; 19% had a history of foster care placement, 6% had spent some time in a prison or detention center, and 15% had lived on the streets.

Uribe and Harbeck (1992) interviewed 37 self-identified gay males and 13 lesbian youth. This sample was obtained from Project 10, a counseling and educational program for gay, lesbian, and bisexual youth at Fairfax High School. Only two males reported positive family relationships. In all cases, family members knew about the youth's sexual orientation, and responses varied from extreme family disruption to forcible expulsion from home. Fifteen of the boys were living with friends, two described living with "sugar daddies," and three were in residential of foster homes for gay adolescents. Half of the study participants acknowledged engaging in suicide attempts in the years prior to the interview (p.22). It was difficult to ascertain if these reported suicide rates included the 13 females in their analyses. A limitation in this study is that the living arrangements of lesbian participants were not reported.

Another study by Rotheram-Borus and colleagues (Rotheram-Borus, Hunter, & Rosario, 1994) found an association between suicide attempts and disrupted family relations in their sample of 136 homosexual and bisexual males aged 14 to 19. Comparisons of youth who attempted suicide to those who had not attempted suicide revealed that attempters were approximately two and one-half times more likely to live outside their homes (39% vs. 21%) and to have dropped out of school (37% versus 19%) than those who made no attempts.

Schneider and colleagues (1989, unpublished observations; as cited in Kruks, 1991) report that 53% of gay street youths in their sample attempted suicide at least once, and 47% more than once. The suicide attempt rate was 32% for all street youth which included 11% gay identified youths. Schneider and colleagues (1989) for their sample of 108 men in gay college organizations and rap groups, also reported a significant correlation between suicide attempts and rejection by social supports, including reduced or broken ties with families and friends. In analyzing the differences between attempters (20% of their sample) and nonattempters, recently suicidal gay men may have more supports viewed as rejecting of their sexuality, depend more on these supports, and view them as more important.

Several studies of gay adolescents document that peers are extremely important in their lives (Remafedi, 1987a; Rothblum, 1990; Savin-Williams, 1994). Across most studies one of the more critical issues noted by gay youth was social isolation. For example, empirical data from the Institute for the Protection of Lesbian and Gay Youth, Inc. in New York found that of the 329 adolescents in their sample, aged 12 to 21, over 95% of the teenagers stated they frequently felt separated and emotionally isolated from their peers because of feelings of differentness (Martin & Hetrick, 1988). However, similar to the findings from Schneider and colleagues (1989), Martin and Hetrick (1988) also found that gay young people rated social support as being very important to them while simultaneously experiencing people as being more rejecting of them than did other youth .

It seems likely that these results identify a predictor of suicidality among sexual minority youths that is specific to such youths. Accordingly, these feelings of isolation

from their peers is a critical problem for these adolescents and has been linked as a contributing risk factor for suicidality.

Substance Abuse

The age of onset for substance use among all youth has become lower in recent years and has been estimated to be as low as 11.9 for males and 12.7 years for girls (as cited in Gibson, 1989, p.129). This coincides with the age that many youths are becoming aware of a gay or lesbian orientation. As discussed throughout this section, high rates of substance abuse have been reported for youth in general, however, the reported prevalence of substance abuse among gay, lesbian, and bisexual youths is even higher. First, this section cites studies that provide estimates of substance use in the general population. Then rates for gay, lesbian, and bisexual, that can be compared to general population rates, are reviewed. Last, this section reviews studies that directly examine the link between substance abuse and suicidality.

Population-based studies.

Blum and colleagues (1989), Blum and Rinehart (1997), and the Centers for Disease Control (1996) included questions about substance use and abuse in their surveys directed at investigating adolescent health. These studies report that approximately 2% of

youth drink alcohol or smoke marijuana daily. Approximately 6% of students report using marijuana weekly or more frequently, and up to 9.9% report weekly alcohol use. The Centers for Disease Control reports 2% of youth have ever injected illegal drugs and 20% have sniffed or inhaled intoxicating substances. Blum and colleagues report that less than 5% of youth have tried cocaine or crack.

Three studies, The Seattle Teen Health Risk Survey, Massachusetts Youth Risk Behavior Survey, and the Vermont Youth Risk Behavior Survey (Safe Schools Coalition of Washington, Fall 1997), described in more detail previously in this paper, compared heterosexual students to sexual minority youth. These studies report that gay, lesbian, and bisexual youth were significantly more likely to use alcohol and other drugs. Specifically they were twice as likely to report binging on alcohol (5+ drinks at one time) at least once in the past month and twice as likely to report smoking cigarettes (SEA, VT) and using marijuana in the past month. Gay youth were three to ten times as likely to report having ever tried cocaine, two to three times as likely to report having tried inhalants (SEA, VT), and three to four times as likely to have ever tried hallucinogens, depressants or stimulants (SEA).

The Seattle Teen Study further reported that gay, lesbian, and bisexual students were over half as likely as their heterosexual peers to report high or heavy drug use. Students were classified as engaged in "high risk or heavy drug use" if they reported having used, in the past month, either 3+ different drugs (including alcohol, marijuana, inhalants, depressants, stimulants, hallucinogens, steroids, and/or any form of tobacco, or 2+ drugs 3+ times, or heroin or cocaine 1+ times, or any drug 10+ times, or having had 3+ episodes of binge drinking (5 drinks in a row for males, 4 for females) in the past month,

or having been "high" at school 3+ times in the past month, or having ever (not just in the past month) injected an illegal drug or shared needles. This study (SEA) also found that heterosexual students who had been targets of anti-gay harassment or violence, despite their self-perception as heterosexual, reported significantly increased risk for engaging in heavy or high risk drug use (Safe Schools Coalition of Washington, Fall 1997).

A major finding for this section, is found from these three studies. These studies provide evidence that lesbian, gay, and bisexual youths are significantly more at risk for both substance abuse and suicide attempts. Fiqures were not provided for the rates of substance abuse among suicidal youth in these studies. However, in the general population, substance use and abuse have been found with great frequency among suicide completers and suicide attempters (Berman & Jobes, 1991; CDC, 1991). According to Berman and Schwartz (1990; as cited in Berman & Jobes, 1991), "In studies of adolescent substance users, suicide attempts have been found to occur at rates three times those of controls, with the 'wish to die' increasing dramatically after the onset of substance use" (p.91).

The National Lesbian Health Care Survey (Bradford et al., 1994, p. 235) also sought to investigate the frequency of alcohol and drug use among their 1,925 respondents. For respondents aged 17 to 24 (8.9% of sample), 32% reported that they used tobacco daily, with another 8% reporting that they smoked cigarettes at more than once a month. The findings from this age group also reported that 3% drank alcohol daily, 29% more than once a week, and 40% more than once a month. Among the sample as a whole, there was a high prevalence of tobacco use (almost one-third), drank alcohol more

than once a week (30%) with 6% reporting they drank daily, and one in five reporting they smoked marijuana more than once a month.

In comparing the frequency rates of alcohol and drug use among the lesbians in this sample with rates for heterosexual women reported in other studies, they found a significant difference. Lesbians show an elevated rate of substance use across all age groups and rates of alcohol use do not seem to decline with age as they do among heterosexual women (Bradford et al., 1994, p.240). Similar to the other studies, Bradford and colleagues did not report rates of substance abuse for those reporting suicidality in their sample.

The population-based studies, most significantly the studies reported by The Safe Schools Coalition of Washington (Fall 1996; Fall 1997), provide much needed data about substance abuse among adolescents and young adults, including gay youth. The studies that used volunteer samples of self-identified gay, lesbian, and bisexual youth more directly examined the link between substance abuse and suicidality.

Volunteer samples of self-identified gay, lesbian, and bisexual youth.

Rotheram-Borus, Rosario, Meyer-Bahlburg et al.(1994) examined the lifetime and current sexual and substance use behaviors of 131 predominately Hispanic and Black gay and bisexual adolescent males in New York City. Lifetime rates, with similar rates for the three months prior to completing the survey, for four substances were high: alcohol (76%), marijuana (42%), cocaine/crack (25%, with 25% cocaine and 8% crack), and hallucinogens(15%). Statistical comparisons with data drawn from a 1991 national

household survey revealed that substance abuse was significantly higher among gay and bisexual male adolescents than male heterosexual youths. For example, the lifetime prevalence rates for gay and bisexual youth were 50% higher for alcohol (76% versus 49%), 2 times higher for marijuana (42% versus 21%), and 13 times higher for cocaine/crack (25% versus 2%). Similarly, the frequency of using alcohol, marijuana, or cocaine/crack at least once a week was approximately 3 to 15 times higher for gay and bisexual male youth during the past three months compared to male youths in the national survey during the past year. This study did not directly investigate the association between substance use and suicidality.

In two studies conducted by Remafedi (Remafedi, 1987a; Remafedi et al., 1991) risk factors for attempted suicide in gay and bisexual male youth were examined. In his earlier study (Remafedi, 1987a) of 29 gay and bisexual male teenagers, aged 15 to 19, 83% admitted to past or current use of illicit drugs, 14% considered themselves to be chemically dependent, 17% had undergone chemical dependency treatment, and 58% met DSM III criteria for substance abuse. Five years after this study was conducted, Remafedi and colleagues (Remafedi et al., 1991) supported these findings through the high rates of substance abuse reported among their sample of 137 adolescent and young adult gay and bisexual males. In comparing gay and bisexual suicidal attempters with nonattempters, Remafedi and colleagues (1991) found that 85% of attempters reported illicit drug use, and 22% had undergone chemical dependency treatment. Sixty-three percent of gay and bisexual nonattempters also were found to have engaged in illicit drug use. In both studies distressingly high rates of substance abuse were reported, however, even higher rates were found among suicide attempters as compared to nonattempters.

Another study (D'Augelli & Hershberger, 1993; Hershberger et al., 1996) that found a strong link between substance abuse and suicidology among gay youth differed from Remafedi (1987a; Remafedi et al., 1991) and Rotheram-Borus, Rosario, Meyer-Bahlburg et al.'s (1994) studies in that it included females in its sample. This is a strength of this study as data directly addressing substance abuse and suicidology among lesbian youth is quite rare. The findings from this study report that 29% of the respondents reported having thought about killing themselves sometimes or often. Thoughts of suicide were significantly related to worries related to excessive alcohol use and drug use (D'Augelli & Hershberger, 1993).

Uribe and Harbeck (1992) in their study also included 13 lesbians in their sample of 50 gay respondents. They report that 36 of the 37 male and 7 of the 13 female respondents admitted problems with alcohol and substance abuse. Half of the male study participants and almost 25% of the female participants reported suicide attempts. In acknowledging the limitations of having such a small sample, most specifically of gay identified female youths, these findings provide useful information but replication of this research needs to be conducted with a larger sample.

The studies presented in this section strongly suggest that substance abuse is prevalent and more frequent among gay, lesbian, and bisexual youth than heterosexual youth. In summary, alcohol and drug use is a risk factor for suicide for both heterosexual and gay, lesbian, and bisexual youth. However, alcohol and drug use is more prevalent in gay, lesbian, and bisexual youth so risk is a matter of degree.

Gender Role Nonconformity/Atypicality

As stated by Harry (1994), "Few values are as intensely and ubiquitously held as those of gender. The norms governing gender-appropriate behavior widely serve as personal standards for judging the gender adequacy of both self and others...Gender is valued so intensely that many persons are willing to kill or die in defense of their gender adequacy(p.70)". The findings from the studies presented in this section confirm that the isolation associated with rejection due to gender inadequacy during adolescence may become a persistent pattern and enhance the likelihood of subsequent suicidal behaviors.

Population-based studies.

One of the strongest population-based studies to date to address the impact of gender nonconformity, or perceived nonconformity, was conducted by the Safe Schools Anti-Violence Documentation Project (Safe Schools Coalition of Washington, Fall 1995; Safe Schools Coalition of Washington, Fall 1997).

The Project defines anti-gay sexual harassment as harassment on the basis of actual or perceived sexual orientation and harassment involving the use of anti-gay epithets (Safe Schools Coalition of Washington, Fall 1995). The study results revealed that actual sexual orientation is apparently not the primary determinant of whether a teen is targeted for harassment. More often than not, offenders had no direct knowledge of their victim's sexual orientations and some targets were heterosexual. Among the 107 targeted youth, the salient factor reported for making a person vulnerable to anti-gay harassment and

violence was the offender's perception of the targeted person's sexual orientation. Over 25% of offenders atributed sexual orientation to gender role non-conformity.

The National Longitudinal Study of Adolescence (Blum & Rinehart, 1997; Resnick et al., 1997) did not directly inquire about gender nonconformity but investigated the impact of being "out of sync" with one's peers. The findings from this report state that teens who are "out of sync" with their peers were at greater risk for emotional distress, suicidal ideation, and attempted suicide.

Volunteer samples of self-identified gay, lesbian, and bisexual youth.

"Many gay youth will have an atypical social role that includes gender nonconformity (Gibson, 1989, p.121)". Several researchers (Harry, 1989; Harry, 1994; Pilkington & D'Augelli, 1995; Remafedi, 1991; Remafedi, 1994; Remafedi et al., 1991; Sears, 1991) have confirmed that gender nonconformity is a contributing risk factor for suicidology among gay male and lesbian youth (Pilkington & D'Augelli, 1995; Sears, 1991).

In a study of 36 Southern lesbians and gay men, approximately 60% of the sample reported that they failed to conform to sex-typed personality traits and interests and displayed cross-gender behaviors during childhood (Sears, 1991). The consequences suffered by these males and females that displayed gender nonconformity differed between the genders. All but one of the 14 males in this study who displayed gender inappropriate behaviors experienced sustained and extensive harassment; only one woman reported

these problems. A unique strength of this study is the focus on experiences of gay youth growing up in the South. A possible limitation of this study is the use of retrospective self-reports. The sense of "being different" as a child or adolescent may be an adult interpretation of earlier life events, rather than a true experience. Sears reports that two-thirds of the youth in his study repeatedly contemplated suicide during high school, and four of the participants attempted suicide.

Similar to Sears (1991), Pilkington and D'Augelli (1995) reported that the frequency with which lesbian, gay and bisexual youth experienced abuse was significantly related to being more obviously lesbian or gay, and/or more gender atypical. This study, however, did not attempt to determine if abuse was correlated with increased risk for suicidology.

Harry (1994) analyzed data from a 1969-1970 San Francisco survey of 686 homosexual males, 337 heterosexual males, 293 homosexual females, and 140 heterosexual females. The findings revealed that departure from gender-appropriate behavior during adolescence was correlated with suicidal feelings and attempts. Gender non-conformity was more common among gays and lesbians, but was associated with suicidality among both heterosexuals and homosexuals. Early gender deviance was more predictive of subsequent suicidality among men than among women. This is one of the stronger studies to address the relationship between gender-role nonconformity and risks for suicidality. This study had a reasonably sized sample and, unlike most other studies, it included both heterosexuals and females, not just gay males.

Almost 20 years later, Remafedi and colleagues (1991) report similar findings in their study of 137 gay and bisexual males, aged 14 to 21. Gender non-conformity was a

significant predictor of self-harm. Compared with nonattempters, suicide attempters had more feminine gender roles.

In summary, studies suggest that growing up homosexual in a heterosexist culture contributes to many of the problems of gay youth. Failure to conform to gender atypical roles is significantly associated, most especially for males, with isolation and victimization. Both social isolation and victimization have been factors contributing to suicide, suicidal attempts, and suicidal ideation in heterosexuals and homosexuals.

Younger Age at Time of Gay Identity Formation

There appears to be a connection between sexual milestones and suicide attempts. Younger gay, lesbian, and bisexual adolescents may be at highest risk for dysfunction because of emotional and physical immaturity, unfilled developmental needs for identification with a peer group, and their dependence upon parents who may be unwilling or unable to provide emotional support around the issue of homosexuality (Remafedi, 1987a). The studies presented in this section provide evidence that forming a gay identity at a younger age has been associated with increased risk for suicidology.

Population-based studies.

Exploration of sexual orientation is a highly salient part of gay and lesbian youth's identity search. In comparison, this type of exploration is seldom part of a heterosexual youth's identity search. The only population study that addressed age of sexual identity as being a risk factor for suicide attempts was conducted by Bell and Weinberg (1978). As described in Chapter I, Bell and Weinberg's sample was obtained in 1969-1979 and consisted of residents from the San Francisco area. They found that over half of the suicide attempts made by the gay and lesbian population they studied occurred at age 20 or below with nearly one-third taking place before age 17. Data that support a relationship between earlier age of sexual identity formation and risks for suicidality have been obtained primarily from studies that used volunteer samples of self-identified gay, lesbian, and bisexual youths.

Volunteer samples of self-identified gay, lesbian, and bisexual youth.

Remafedi and colleagues (1991) in their study of 137 gay and bisexual males, aged 14 through 21, found that youth who attempted suicide averaged age 15.5 years at the time of their attempt. Statistical analysis also revealed a statistically significant inverse relationship between age of first gay self-labeling and suicide attempts. One-third of first suicide attempts occurred in the same year that subjects identified their bisexuality or homosexuality; most other suicide attempts occurred soon thereafter. These findings supported an earlier study by Remafedi (1987a) that found that 34% of his sample of 29 gay and bisexual teenagers had attempted suicide, and that half of those who had made an attempt(s) directly related it to issues regarding conflict with sexual identity. Eight (80%)

attempts chronologically followed the individual's self-identification as homosexual. Schneider and colleagues (1989), in their sample of 108 gay men, also found a relationship between the emergence of homosexuality and suicide attempts. Suicide attempters reported being significantly younger when they were first aware of being attracted to members of the same sex (age 8.1 versus 10.7 for nonsuicidal gay youth), labeling their feelings as homosexual (age 12.1 versus 14.1), questioning heterosexual identity (age 13.8 versus 15.1), and involved in first homosexual relationship (16.2 versus 17.7). Suicide attempters, compared to nonsuicidal gay youths, reported that they were grappling with their homosexuality earlier in adolescence, and at the time of their first attempt, most were aware of their homosexuality, but had not yet felt good about themselves as gay men. Nonsuicidal gay youth were "coming out" somewhat later than the attempters, the differences observed were on the order of 1 to 3 years.

In summary, there is a strong consistency across all studies revealing the younger the age at time of gay identity formation the greater the probablility of a suicide attempt.

Religiosity

Religion presents another possible risk factor in gay youth suicide because many traditional faiths still portray homosexuality as morally wrong or evil. First, in subscribing to the belief that homosexuality is a sin, these faiths contribute to the rejection of gay youth by their families, peers, and society at large. It has been traditional wisdom in suicidology, following the work of Durkheim, that integration in religious networks and

institutions protects individuals against the risk of suicide. "While this theory presumes that it is integration within a stable social structure implied by religious participation that protects against suicide, it is also possible that the formal values or ideologies of religion prohibiting suicide also inhibit suicidal behavior (Bagley & Ramsay, 1997, p.33)". It appears that religion greatly influences the formative experiences of many youths. However, as will be discussed in this section, it appears that more gay, lesbian, and bisexual youths as compared to heterosexual youth report to have no religious affiliation.

Population-based studies.

No popoulation studies directly addressed the relationship between religion and suicide among gay, lesbian, and bisexual youth. The literature does show, however, gay, lesbian, and bisexual youth report less religious affiliation than heterosexual youth; and, that religious affiliation and prayer are associated with less drug use and sexual activity among youth.

The earliest study to investigate the role of religion among homosexuals in comparison to heterosexuals was conducted by Bell and Weinberg (1978). Their data confirm that homosexual adults tend to be more alienated from formal religion than are heterosexuals. A more recent population-based study that investigated the relationship between religiosity and health risk behaviors in adolescents was conducted by Blum and Rinehart (1997; Resnick et al., 1997). The findings from this comprehensive study show that religion and prayer is associated with decreased frequency of substance abuse/use and delay of sexual activity. The relationship between suicidality and religion was either not

examined or not reported by these researchers. Bradford and colleagues (1994) in their study sample of 1,917 lesbians, found that 66.2% of their sample reported having no religious affiliation. It does not appear that these researchers investigated the impact of this factor on suicidality.

The population studies reviewed provided very limited information about the association between religion and suicidology among youths in North America. However, studies that used volunteer samples of self-identified gay people, did investigate this relationship more thoroughly. The relationship between religiosity and suicidality among gay, lesbian, and bisexual youths received far less attention in the literature than the other variables presented throughout this paper.

Volunteer samples of self-identified gay, lesbian, and bisexual youths.

Sears (1991), in his study of 36 gay youth from the South, devoted considerable attention to the relationship between homosexuality and religion in the South, particularly for the African-American participants. The life stories of the African American males in the study illustrate how their families' religious faith and its intersection with black community, culture, and history affects these youths' emerging homosexual identity. The African-Americans in this study emphasized the importance of religion in their family, community, and history and reported this religious tradition had positive and negative blessings. For example, the religious rituals grounded Blacks in a community of shared

history and values. The animosity expressed in their churches toward homosexuality, however, distanced them from this community and its history. Lesbians and gay men of color in this study often chose exile from either their homosexual feelings or their black communities. This study did not analyze the relationship between religion and suicide, but did report that two-thirds of the gay youth repeatedly contemplated suicide during high school.

A second study to inquire about religious affiliation among its sample of 108 gay adolescents and young adults was conducted by Schneider and colleagues (1989). Their findings report that significantly more of the suicidal youths in their sample reported no religion as compared with those who did not attempt suicide.

Remafedi and colleagues (1991) found that, among their sample of 147 self-identified gay (88%) or bisexual (12%) males between 14 and 21 years of age, 27% of the suicidal attempters reported having no religion as compared to 17% of those who did not attempt suicide. Although the effect is small, it appears religiosity was a protective factor against suicide attempts.

D'Augelli and Hershberger (1993), in their study of 194 lesbian, gay, and bisexual youth aged 21 and younger, found that suicidal attempters did not significantly differ from nonattempters in religiosity. In comparison with other studies that found higher rates of suicide attempts and ideation among gay youth that report no religious affiliation, D'Augelli and Hershberger did not inquire about religious affiliation, but seemed to ask about "religious issues about sexual orientation"(p.436). It is unclear how these researchers derived at their conclusion that suicidal attempters did not differ from nonattempters in religiosity.

The research findings suggest that religious affiliation may serve as a protective factor against suicidality. There appears to be a causal link between decrease in religiosity and increased suicide attempts among gay, lesbian, and bisexual youth, although the literature addressing religiosity and suicidality among gay, lesbian, and bisexual youth is very limited and not very strong. The results presented in this section must be interpreted cautiously.

Suicide and Suicide Attempts among Family Members

Exposure to the suicidal behavior of another person appears to be a significant risk factor for subsequent suicidality among heterosexual, homosexual, and bisexual youth. A family history of suicide should be considered as an alerting sign to suicide risk in adolescence. Two population-based studies (Blum et al., 1989; Blum & Rinehart, 1997) and three studies that used volunteer samples of self-identified gay, lesbian, and bisexual youth (Remafedi et al., 1991; Rotheram et al., 1994; Schneider et al., 1989) are presented and discussed in this section.

Population-based studies.

Out of a list of more than 20 potential areas of concern, five stood out as being topics that students in Minnesota (7th, 8th, and 9th grade) were most likely to say that

they worried about "quite a bit" or "very much". One of the most reported worries was about a "parent dying", with 40% of the 36,284 students sampled expressing such a concern. Blum and colleagues (1989) found that over 6.5 percent of their respondents have had a relative who has attempted or successfully committed suicide. They also found that 6% of the female and 3% of male respondents surveyed tried to kill themselves within the past year. These researchers did not report if these suicidal youth had been exposed to suicidality among family members.

Blum and Rinehart (1997; Resnick et al., 1997) more thoroughly investigated the relationship between family suicide attempts/completions and teen health risk behaviors. They found that recent suicide attempts and completions by a family member were a significant risk factor for emotional distress and suicide thoughts or attempts for respondents in grades 7 through 12. Furthermore, these researchers also found that recent family suicide attempts and/or completions were a risk factor for participation in violence for youths in grades 7 through 12. In addition, students (grades 7 through 12) reported more cigarette and alcohol use (in grades 9 through 12) if they had experienced recent family suicide attempts or completions.

Volunteer samples of self-identified gay, lesbian, and bisexual youth.

Remafedi and colleagues (1991) in their study of risk factors for attempted suicide in gay and bisexual youth report that 39% of suicide attempters and 27% of nonattempters were acquainted with a peer who had committed suicide. Thirty-eight percent of suicide attempters, as compared with 22% of youth who had not attempted suicide, had family members who had attempted or completed suicide. In striking contrast to other studies presented in this section, the rates for family suicidality was not found to be statistically significant between the suicide attempters and nonattempters. Remafedi and colleagues addressed these findings as being unusual. Although, they did not explain why these results could have produced different results from other studies.

Schneider and colleagues (1989) found marked trends for familial suicide attempts among their group of suicidal gay male adolescents and young adults. These researchers found that 20.3% of the suicidal gay youth as compared to only 8.2% of the nonsuicidal gay youth reported suicidal attempts among their families.

Rotheram-Borus and colleagues (1994) found the largest difference between suicide attempters and nonattempters in percentage of those who had a family member or friend attempt or complete suicide. A strength of this study is that its sample was ethnically diverse, 51% were Hispanic, 30% Black, 12% White, and 7% Other.

Among the youths, 49% said they had a family member or friend who had attempted suicide. Seventeen percent had a family member who had attempted suicide and 12% had a member who had completed suicide. About one-third said they had at least one friend who had attempted suicide, and 16% reported they had at least one friend who had killed himself or herself. The findings from this study also report that the youth suicide attempters, as compared to the nonattempters, were approximately two and one-half times

more likely to have friends or relatives who attempted suicide (62% vs. 41%). It appears that minority gay male youths may be significantly more at risk for suicide attempts and completions among their network of friends and family members than White gay male youths.

Suicide attempts and completions among friends and family members seems to be a contributing factor for subsequent suicidality among gay male youths. It is difficult to determine if gay youth are more at risk than heterosexual youth due to the limited scope of the literature. Furthermore, differences between gay males and lesbians were unable to be ascertained since studies on lesbians, or studies that included lesbians in the existing literature, are noticeably absent.

Chapter IV

Summary and Conclusions

Prevelance of Suicidality

Despite definition problems and difficulties in measurement, there is consensus in the literature that prevalence of suicidality among gay, lesbian, and bisexual youth in North America is considerably higher than among heterosexual youth. Results from the population-based studies revealed that homosexual male youth are at minimum three to four times more likely to attempt suicide than heterosexual male youth. The rates of suicide attempts for lesbian youth were also high. The suicide attempt rates ranged from 17.7 % to 24% for lesbian youth, in comparison with 5.1% to 14.5% for heterosexual female youth.

The highest suicide attempt rates were obtained from studies using volunteer samples of self-identified gay, lesbian, and bisexual youth. The suicide attempt rates ranged from 20% to 42%, with an average rate of 33% for all studies combined. The empirical data clearly show that youths are at high risk for attempted suicide and suicidal ideation, and that gay, lesbian, and bisexual youth are at much greater risk for suicide than heterosexual youth.

There are several factors which need to be considered when making meaningful comparisons between the results of the population-based studies with those that used volunteer samples of self-identified gay youth. These factors seem likely to effect the

differences found between the rates of suicidality reported. First, adolescents may not be comfortable with acknowledging to others a gay, lesbian, or bisexual identity. Especially, if the questionnaire is being administered in a school setting where peers and school administrators have openly expressed anti-homosexual attitudes. The literature on survey methodology has clearly established that stigmatized behavior, such as same-gender sex, and unpopular beliefs and attitudes are underreported in surveys. Second, homosexual youth may not be ready to self-label as such even to themselves. Given these factors, concealment will be a problem in research with gay, lesbian, and bisexual youth and most likely will result in underestimation of homosexuality and rates of suicidality. Third, it may be speculated that the rates for suicide attempts would be inflated among the volunteer samples of self-identified gay youth if the estimates derived were obtained from clinical samples. In contrast, most of the studies reviewed used volunteer samples obtained from nonclinical or community settings. It seems possible that these visible gay youth may experience less suicidality than gay, lesbian, and bisexual youth that may not be receiving services from community agencies dedicated to helping this population and may even be more alienated and at risk than those sampled. However, a question remains as to how comparable sexual-minority youth who particiapte in youth groups or volunteer to participate in research are to those who do not.

In conclusion, despite the differences in rates across the studies, the implications of the research findings recognize the existence of serious risks for suicidality among gay, lesbian, and bisexual youth.

Contributing Risk Factors for Suicidality

It appears that gay, lesbian, and bisexual youth are vulnerable to similar risk factors for suicidality as heterosexual youth. However, as sexual minorities, these youths encounter unique stressors in their lives that are directly related to their sexual behavior and identity beyond those encountered by heterosexual adolescents and young adults. Consequently, it appears there is not just one risk factor that is most predictive of suicidal behavior. More likely it is an accumulation of experiencing multiple risk factors simultaneously in combination with low rates of protective factors that exacerbate suicidality among homosexual youths. Hence, in order to meet the ultimate goal of providing appropriate prevention and intervention for adolescents and young adults most in need, it is imperative to understand the constellation of risk factors that lead to this increased level of suicidality.

The strongest predictors for suicidality among all youth are substance abuse, victimization, social isolation, and exposure to suicide attempts or completions among family members. Homosexual and bisexual youth show significantly elevated rates for these risk factors. Additionally, there is evidence that gay, lesbian, and bisexual youth experience other contributing risk factors for suicidality that differentiate them from heterosexual youth. The strongest predictors for suicidality, unique for sexual-minority youth, are gender non-conformity and younger age at time of homosexual identity formation. Lack of religious affiliation presents another possible risk factor in gay youth suicide. However, the population-based studies reviewed provided limited information about the association between religion and suicidality among youths. Similar for

heterosexual youth, there is not one risk factor that is most predictive of suicidal behavior among gay, lesbian, and bisexual youth. More likely it is an accumulation of experiencing multiple risk factors simultaneously in combination with low rates of protective factors that exacerbate suicidality among homosexual youths.

Suggestions for Future Research

This paper has identified several limitations in the research literature on suicide and sexual orientation. Research examining suicidality among gay persons is particularly difficult because there is, "a lack of consensus on definitions of fundamental terms such as 'suicide attempt' and 'sexual orientation', uncertain reliability and validity of measures of these terms, nonrepresentative samples, and a lack of appropriate control groups, among other limitations (Muehrer, 1995, p.79)". The following recommendations are suggested for future investigations of attempted and completed suicide among gay, lesbian, and bisexual youth. The suggestions presented do not exhaust the range of activities needed for further research into the contributing risk factors for suicidality among homosexual youth. Nevertheless, they do provide some specific ideas for research addressing the underpinnings of suicide and sexual orientation.

To better understand the prevalence of and contributing risk factors for suicidality among gay, lesbian, and bisexual youth future studies need to consistently incorporate sexual orientation into their research. In conceptualizing the foundations for studies, researchers need to examine if the research question ignores or denies the existence of

lesbians, gay men, and bisexual people. Failure to recognize that most samples will include some gay, lesbian, and bisexual participants can weaken a research design. Furthermore, research should assess sexual orientations in enough detail to capture their complexities, yet retain interpretability. A shortcoming of the research is that the measurements are difficult and problematic to interpret. For example, how does one conceptualize a person whose behavior, fantasies, and affiliation patterns are not congruent? Additionally, different conclusions are likely to be reached with the following operationalizations: self-labeling, self-reports of sexual behavior during a specific time period, and, self-reports of sexual desires or fantasies during a specified time period. Accordingly, because sexual behavior is continually changing it will be necessary to repeat longitudinal studies of adolescent risk-taking behavior in each succeeding cohort of young men and women.

Second, to increase comparability among different studies, research scientists should employ standardized terminology. Standardized criteria and definitions need to be developed and universally applied, especially for such terms as suicide attempts, suicidal ideation, and sexual orientation. In general, researchers are encouraged to measure suicidality and sexual orientation in more thoughtful, accurate, and meaningful ways.

Third, when research results are to be generalized to the entire population of gay youth, researchers should strive to use standard sampling procedures in order to obtain the most representative sample possible. What is needed is more multisite (urban, suburban, and rural), population-based, longitudinal studies. Also, future research needs to ensure that the entire spectrum of gay youth is adequately represented. For example, future investigations of suicidality should address the issue of suicide risk for young gay and bisexual females, as well as culturally/ethnically diverse gay youth. Due to the nature and

scope of conducting population-based, longitudinal studies, it seems the most appropriate government agencies to sponsor these future research studies would be federal agencies such as the Centers for Disease Control and the National Institute of Mental Health.

Fourth, control groups and comparison groups need to be used and should be carefully selected. For example, while comparing suicidal with nonsuicidal youth, it can only show that one specially defined population may differ from another specially defined population. It would be most desirable to obtain control groups from nonclinical populations through conventional methods of survey research. For example, it is recommended that researchers use a probability sample of the community, or if feasible, use a multisite design or multistage, stratified, clustered sample to increase representativeness and generalizability of findings. However, while waiting for more large scale longitudinal investigations to be funded, studies which use volunteeer samples of homosexual and bisexual youth are encouraged to be continued.

Fifth, the psychological autopsy is an important research technique and is strongly encouraged for future studies investigating the relationship between sexual orientation and suicide. However, as presented earlier in this paper, sexual orientation is not noted on the death certificate and many parents and family members may not be aware of their deceased child's sexual history. Tremblay (1998) suggests that researchers need to assess the viability of using psychological autopsy reports with this population. For example, he postulates that researchers have yet to ask certain questions from gay youth who made suicide attempts. "If you had died, would your parents or teachers have known that you were gay and homosexually active? Would a friend whom your parents had told

a researcher to talk to have known the truth? If so, do you think this person would have revealed your secret to anyone?" He further suggests that researchers should inquire, "If you had died, is there a way that a good investigator could have obtaine the information needed to prove that you were gay or bisexual, and maybe homosexually active?" Future research that seeks to improve the design and demonstrate the utility of psychological autopsy reports with this population is strongly warranted and much encouraged.

Sixth, in conducting research on suicidality and sexual orientation among youth, it is imperative to assure privacy and confidentiality of all study participants. Future research should consider employing the use of new technology where study participants enter their survey responses into a laptop computer. This may greatly reduce parental or interviewer influences on the youth's responses and lessen concerns related to confidentiality. Because of the sensitive nature of research on sexual orientation, researchers must also carefully consider whether parental consent is in the best interest of study participants below the age of majority.

Last, "while gay men and lesbians are at risk for suicide, it is critical to note that belonging to a group at risk for suicide does not make every individual suicidal (Saunders & Valente, 1987, p.20)". Therefore, research is encouraged that investigates the experiences of those gay, lesbian, and bisexual youth who report effectively navigating their life course without incidence of suicidality. Information derived from studying this population could provide valuable insights and uncover strategies that could be useful for those youths less fortunate.

In summary, the science of psychology requires studying human behavior in all of its diversity. It is most appropriate, therefore, that mental health professionals address

issues relevant to sexual orientation in research with general samples and also conduct research with gay, lesbian, and bisexual youth from diverse cultural backgrounds. A variety of research questions, disciplines, and methods is needed to continue to unravel the issues associated with prevalence of and contributing factors for suicidality among gay, lesbian, and bisexual youth. More focused studies that link and expand our knowledge about appropriate preventive and interventive clinical techniques in assisting gay, lesbian, and bisexual youth should be top priorities for research. Beyond academic interest, research pertaining to homosexuality and suicide has important implications for clinical practice.

Clinical Implications

The multiplicity of risk factors described throughout this paper could end the lives of many gay, lesbian, and bisexual youth. Knowing information about these risk factors may help mental health professionals better serve this population. This knowledge may enhance clinicians' and other mental health professionals' ability with assessment, diagnosis, prevention and treatment of suicidality among homosexual and bisexual youth. An important factor for mental health professionals working with gay and lesbian clients is that the therapist must be supportive of the adolescent and must feel comfortable with the issues of homosexuality and sexuality in general.

Assessment

In assessing treatment needs of gay, lesbian, and bisexual youth, findings from this literature review suggest several issues to explore. An important first step in promoting health for this population is for clinicians to attempt to understand the meaning and experience of being homosexual and a teenager. Second, mental health professionals need to be cautious when making assumptions regarding a youth's sexual orientation. Complete sexual histories, including questions about sexual orientation and behaviors, should be included in the information gathered. For example, Kourany (1994) was surprised to find in his survey of 66 adolescent psychiatrists, that many acknowledged limited or no experience in dealing with homosexual adolescents. Although, the majority of respondents agreed that these teenagers were at higher risk for suicide and that their gestures were more severe it appears likely that these psychiatrists did not inquire about sexual orientation, leading one to think perhaps they assumed all their patients were heterosexual. Third, gay youths need to be specifically assessed for risk factors contributing to suicidality including: substance abuse, home and school problems, victimization, interrupted social ties, gender nonconformity, religiosity, suicide attempts or completion among family and friends, and earlier age of homosexual identity formation. Questions aimed at assessing these dimensions should be presented in culturally sensitive language and terms.

Brief Suggestions for Interventions

An extensive discussion about specific therapy techniques and strategies is beyond the scope of this paper. Based upon the findings from the literature, specific recommendations for clinical interventions are presented for the strongest contributing risk factors for suicidality among gay, lesbian, and bisexual youth. Across all domains, intervention efforts which fail to recognize a youth's homosexual or bisexual orientation, will fail to help them effectively cope with risk factors contributing to suicidality.

Like heterosexual youth, substance abuse and victimization are consistently reported as risk factors for suicide attempts among homosexual and bisexual youth. The rates, however, are significantly elevated for gay, lesbian, and bisexual youth as compared with heterosexual youth. A comprehensive review of interventions for substance abuse and victimization can be found throughout the clinical and/or medical literature. However, mental health professionals working with homosexual and bisexual youth need to take into account the special needs of this population when they design substance abuse treatment plans and programs. For example, the mental health professional needs to consider how drugs in relation to sexual oreintation or behavior may lessen the subjective pain of feeling alone or rejected, decrease the sense of worthlessness, and reduce guilt or shame. To assist in not internalizing the effects of victimization, homosexual and bisexual youth will need help with developing effective interpersonal coping mechanisms. This is a salient factor for treatment with this popoulation since societal stigmatization is prominant for sexual minority youth. The clinician also needs to be able to provide, or be able to refer homosexual and bisexual youth, to nurturing, gay-affirming, support groups. Mental health professionals can assist these youth, who are often targeted for verbal and physical

harrassment, by becoming more involved in providing educational and counseling services within the school community.

Social isolation and interrupted social ties were also found to be strong risk factors for suicidality. Gay, lesbian, and bisexual youth have reported they feel alone in the world, no one else is like them, and that they have no one with whom they can confide. Homosexual youth seem to experience increased risk of losing friends and family ties because of sexual orientation. As suggested previously, mental health professionals may help these clients by being knowledgeable about the homosexual community and available resources for support. These support services can provide adult as well as peer role models, assess to accurtate information, and someone to talk to openly. Since difficulties with parents is among the most significant problems reported in the lives of many homosexual youth, family therapy may be beneficial in reconciling or reuniting these youth with their families. However, all factors need to be taken into consideration before recommending the family join in the therapy sessions. Furthermore, the task of sorting through the anxiety, anger, and disillusionment typically felt toward parents at this time becomes more complex for gay, lesbian, and bisexual youth. For example, homosexual youth must reevaluate parental values and expectations and be assisted with adopting those values which are most congruent with a positive homosexual identity.

Risk factors found to be unique for suicidality among gay, lesbian, and bisexual youth include gender role nonconformity and younger age of homosexual identity formation. Lack of religious affiliation presents another possible risk factor in gay youth suicide. However, the population-based studies reviewed provided limited information about the association between religion and suicidality among youths. Gender role

nonconformity is associated with alienation from peers, most specifically among males. Mental health professionals can best assist by providing these youth with the opportunity to socialize and interact in a non-threatening and healthy environment. These opportunities should help these youths develop stronger coping skills and interpersonal resources. Given the information presented above, these same opportunities may assist gay, lesbian, and bisexual youth in developing appropriate strategies, and provide positive support and validation, in their search for sexual identity formation. Last, at some point in the counseling process, it may be beneficial to question the youth about the impact of homosexuality on their religious beliefs. For example, it may be helpful to learn if the youth views him or herself as sinful, bad, weak, or inadequate. Religious affiliation may provide a sense of something greater than self or other human beings, a sense of community, answers to universal questions, and moral guidance. These needs are often not met for many gay, lesbian, and bisexual youth because most religious teachings are not congruent with a homosexual identity or lifestyle. In response, the homosexual and bisexual youth may struggle with issues and concerns that heterosexual youth do not. Religion and spirituality may be important issues in therapy with gay, lesbian, and bisexual youth.

This section has only highlighted a few of the most general clinical implications for suicidal youth who are gay, lesbian, or bisexual. In summary, these youth are faced with the same, however some differing, developmental tasks than heterosexual youth. These tasks may involve sorting through the meaning, management, and expression of their sexuality.

Signs of progress.

"Despite the impediments to the recognition and care of sexual minority youths, there has been noticeable progress during this decade in the education of health professionals and in the provision of services (Remafedi, 1987b, p.225)". Furthermore, in more recent years, there have been a few population-based studies that have embedded questions about sexual orientation in their studies about health risk behaviors for youth. Although these are relatively small steps, taken the apparent seriousness of the problem of suicidality among gay, lesbian, and bisexual youth, these steps create reason for optimism. In conclusion, all homosexual and bisexual youth deserve dignity and respect and are entitled to sufficient support from societal systems to enable them to achieve their fullest potential. Mental health professionals have a responsibility to make the world as accepting of gay, lesbian, and bisexual youth as possible, and to model responsible caring behavior.

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